DEPA GENT	RTMENT OF HEALTH	AND HUMAN SERVICES	ر الم		RINTED: 08/31/20- FORM APPROVE
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP		MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME D	F PROVIDER OR SUPPLIER	445239	8. WING		00/20/204=
	ARE CENTER OF MORI	TEMENT OF DEFICIENCIES] 4	STREET ADDRESS, CITY, STATE, ZIP CODE 119 SOUTH KINGSTON STREET WARTBURG, TN 37887 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IN	08/28/2017 36 (XS) 36 COMPLETION
	REGULATORY OR ES	SC (DENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION ATE DATE
K 000			K 000		: :
	health licensure and care facilities on 8/20 survey, Life Care Ce not found to be in su requirements for par Medicare/Medicaid a Life safety from fire,	was conducted by the state of ent of Health, Division of regulation office of health 8/17. During this life safety enter of Morgan County was bstantial compliance with the ticipation in at 42 CFR Subpart 483.70(a), and the related National Fire in (NFPA) standard 101 -			:
K 291 SS=F	The requirement at 4 NOT MET as evidence NFPA 101 Emergence		K 291	K 291	09/01/17
	Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain the emergency lighting. This deficiency was 3 of 6 smoke compartments.			What corrective actions will be accomplished for those reside found to have been effected to the deficient practice?	ents
	NHPA 101, 19.7.6 & 7,	.9.3.1		The facility completed and documented the 90 min, test	that
	The finding includes:			is required. The wires were removed and tested on batter	ļ
	maintenance director of revealed the 90 minute emergency lighting wa	is not being conducted.		power for 90 mins by the maintenance director on September 1 st . This includes	all .
	ienciency was identifie	ctor was present when the ed and was acknowledged		exit signs throughout the facil	ity.
RATORY	DIRECTOR'S OF PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNAT	TURE	TITLE	

(X6) DATE

In deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther saleguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days bliowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

STATEM	ENT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Tara			FORM A)8/31/2017 PPROVEC 938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE C	(X3) DATE SURVEY COMPLETED			
NOME	- 000140E	445239	B, WING				
LIFE	OF PROVIDER OR SUPPLIER CARE CENTER OF MOR	<u></u>		419 5	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH KINGSTON STREET RTBURG, TN 37887	08/28	/2017
(X4) IE PREFIX TAG	く しゅうか ひきがいけんじん	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	· ·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5c a	(X5) OMPLETION DATE
K 00	0 INITIAL COMMENT	s	K 00	o			
	health licensure and care facilities on 8/26 survey. Life Care Ce not found to be in surequirements for part Medicare/Medicaid a Life safety from fire, 3 Protection Associatio 2012 edition.	f 42 CFR Subpart 483,70(a), and the related National Fire n (NFPA) standard 101 -					
K 291 SS=F	NOT MET as evidend	2 CFR, Subpart 483.70(a) is ced by: y Lighting	K 291	2.	How will you identify other		
Emergency Lighting Emergency Lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation, record review and	residents having the potential be effected by the same defici- practice and what corrective action will be taken?						
	interview the facility failed to maintain the emergency lighting. This deficiency was 3 of 6 smoke compartments.				This exercise will be done annuthroughout the building and	•	
	NFPA 101, 19.7.6 & 7. The finding includes:	9.3.1	,		documented. The documental will be in the maintenance director's office.	นอก	
	maintenance director of revealed the 90 minute emergency lighting wa	e annual testing on s not being conducted,		3.	What measures will be put in place or what systematic chan you will make to ensure that the deficient practice does not recommend.	<u>he</u>	
	deficiency was identifie	ctor was present when the ed and was acknowledged				<u>.</u>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Derecta

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 stays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

TATEME	NT OF DEFICIENCIES	& MEDICAID SERVICES	T		OA	FORM APPROV 1B NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 81 - MAIN BUILDING 81			(X3) DATE SURVEY COMPLETED	
NAME OF		445239	B. WING			
	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	08/28/2017
	ARE CENTER OF MOR				SOUTH KINGSTON STREET RTBURG, TN 37887	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) SE COMPLETIO ATE DATE
K 000	INITIAL COMMENT	s	K 00	00		
K 291 SS=F	nealth licensure and care facilities on 8/2i survey, Life Care Ce not found to be in surrequirements for par Medicare/Medicaid & Life safety from fire, Protection Association 2012 edition. The requirement at 4 NOT MET as evident NFPA 101 Emergency Lighting Emergency Lighting of is provided automatical 8.2.9.1, 19.2.9.1 This STANDARD is 1	and the related National Fire on (NFPA) standard 101 - 2 CFR, Subpart 483,70(a) is ced by: by Lighting f at least 1-1/2-hour duration ally in accordance with 7.9.	K 29	7	Monthly checks of all emerger lighting will be done by the Maintenance Director and checked by the Executive Director will be accomplished duri	ctor.
	Based on observation interview the facility faci	n, record review and ailed to maintain the This deficiency was 3 of 6			rounds that are made and documented.	ng : :
	NFPA 101, 19.7,6 & 7	.9.3.1		А	Characterist & Landers and the second	£ .
	The finding includes:			4.	How will the corrective action monitored to ensure the defic	· ·
1	maintenance director revealed the 90 minut	eview and interview with the on 8/28/17 at 8:43 AM e annual testing on as not being conducted.			practice will not recur?	
- C	The maintenance dire deficiency was identific	ctor was present when the ed and was acknowledged				

Any definiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/31/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445239 B. WING NAME OF PROVIDER OR SUPPLIER 08/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF MORGAN COUNTY 419 SOUTH KINGSTON STREET WARTBURG, TN 37887 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 8/28/17. During this life safety survey, Life Care Center of Morgan County was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483,70(a). Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 -2012 edition. The requirement at 42 CFR, Subpart 483,70(a) is NOT MET as evidenced by: K 291 NFPA 101 Emergency Lighting K 291 SS=F The Maintenance Director will **Emergency Lighting** report findings of the monthly Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. audit to the PI committee. The 18.2.9.1, 19.2.9.1 committee consists of the This STANDARD is not met as evidenced by: Based on observation, record review and Executive Director, DON, ADON, interview the facility failed to maintain the Medical Director, Director of emergency lighting. This deficiency was 3 of 6 Rehabilitation, Director of Health smoke compartments, Management, Dietitian, Director NFPA 101, 19.7.6 & 7.9.3.1 of Maintenance, Director of Environmental Services, Director The finding includes: of Social Services, Business Office Observation, record review and interview with the Manager, Activities Director, and maintenance director on 8/28/17 at 8:43 AM Staff Development Director for revealed the 90 minute annual testing on emergency lighting was not being conducted. the next 3 months.

ABOBATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The maintenance director was present when the deficiency was identified and was acknowledged

Executive Dens Total

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 deficiencies are cited, an approved plan of correction is requisite to continued regram participation.

NFPA 101, 19.3.2.5.3 NFPA 96, 10.2.7.3 action will be taken?

This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the commercial cooking equipment. This deficiency affected 1 of 6 smoke compartments.

NFPA 101, 19.3.2.5.3 NFPA 96, 10.2.7.3 How will the corrective action be monitored to ensure the deficient

practice will not recur?

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/31/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445239 B. WING 08/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF MORGAN COUNTY 419 SOUTH KINGSTON STREET WARTBURG, TN 37887 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY

K 324 Continued From page 2

The findings include:

Observation and interview with the maintenance director on 8/28/17 at 9:30 AM revealed;

- The ANSUL hood suppression nozzles were not aimed at the cooking surfaces, they were rotated to the rear and the top shelf was obstructing them.
- 2. There was excessive grease build-up on the stove top and behind the fryer.

The maintenance director was present when the deficiencies were identified, and was acknowledged by the director of nursing during the exit conference on 8/28/17.

K 521 NFPA 101 HVAC

SS=F

HVAC

Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.

18.5.2.1, 19.5.2.1, 9.2

This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain fire dampers. This deficiency affected 6 of 6 smoke compartments.

NFPA 101, 19.7.6 NFPA 80, 19.4.1.1 K 324

The Maintenance Director will report findings of the monthly audit to the PI committee. The committee consists of the Executive Director, DON, ADON, Medical Director, Director of Rehabilitation, Director of Health Management, Dietitian, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Director for the next 3 months.

K 521

· 7:

09/08/17

 What corrective actions will be accomplished for those residents found to have been effected by the deficient practice?

The facility has corrected and documented all damper inspections throughout the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY

445239

B. WING

08/28/2017

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF MORGAN COUNTY

STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET WARTBURG, TN 37887

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

K 521 Continued From page 3 The finding includes:

Observation, record review and interview with the maintenance director on 8/26/17 at 8:28 AM revealed the damper inspections were started but not complete.

The maintenance director was present when the deficiency was identified and was acknowledged by the director of nursing during the exit conference on 8/28/17.

K 521

building by the Maintenance Director/ Maintenance Assistant on September 8th. These will be checked in accordance with the manufacturer's specifications.

2. How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?

100% audit by the Maintenance Director has been done and all meet the manufacturer's specification. Monthly checks will be completed and documented.

3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur?

Monthly checks by the maintenance department will be done. All dampers will be checked and documented.

PRINTED: 08/31/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445239 B. WING 08/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 419 SOUTH KINGSTON STREET LIFE CARE CENTER OF MORGAN COUNTY WARTBURG, TN 37887 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

K 521 Continued From page 3 The finding includes:

Observation, record review and interview with the maintenance director on 8/26/17 at 8:28 AM revealed the damper inspections were started but not complete.

The maintenance director was present when the deficiency was identified and was acknowledged by the director of nursing during the exit conference on 8/28/17.

K 521 4. How will the corrective action be monitored to ensure the deficient practice will not recur?

The Maintenance Director will report findings of the monthly audit to the PI committee. The committee consists of the Executive Director, DON, ADON, Medical Director, Director of Rehabilitation, Director of Health Management, Dietitian, Director of Maintenance, Director of

Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Director for the next 3 months.